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TEENAGE PREGNANCY AND TOO-EARLY CHILDBEARING:

PUBLIC COSTS, PERSONAL CONSEQUENCES

6th Edition, 1992

Costs to the Federal Government and Selected States and Cities

The Center for Population Options

CPO'S NATIONAL PRIORITIES FOR REDUCING TEEN PREGNANCY AND TOO-EARLY CHILDBEARING

1) National leadership from Congress and the Executive Branch committed to improving the health of children and youth and to providing adequate sexuality education and family planning services for all.

2) Increased federal and state funding for family planning and teenage pregnancy prevention programs.

3) K-12 Family Life Education, incorporating life skills, self-esteem building, comprehensive sexuality education, and life planning. Family Life Education should incorporate parents as much as possible, and foster young people's skills and self-confidence to delay intercourse and childbearing.

4) Affordable health care for youth through school-based or community health clinics that accommodate the needs of youth.

5) Effective contraceptives, including condoms, readily accessible and available to sexually active youth at low or no cost, in a non-judgmental manner that protects confidentiality.

6) Safe, affordable, accessible, and confidential abortion services for teenagers with unintended and unwanted pregnancies who choose not to continue the pregnancy.

7) Federal funding of research on adolescent risk-taking and behavior change, as well as increased funding for scientific evaluation of model programs, to improve the effectiveness of interventions and avoid waste.

8) Coordinated community efforts to provide education, services, and options for hard-to-reach or at-risk youth.

9) Increased support for child and adolescent sexual abuse prevention programs, as well as drug and alcohol abuse prevention programs directed toward adolescents.

10) Television and other media advertising of condoms and other contraceptives for the prevention of pregnancy and sexually transmitted diseases, including HIV.

11) Cooperative ventures among private and public agencies to offer vocational planning, job skills training and economic opportunities to teenagers.

12) Education, outreach and pre- and post-natal services for pregnant teenagers who choose to carry a pregnancy to term, including programs to help parenting teens remain in school.

Credits

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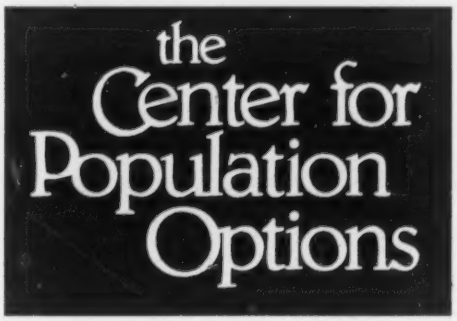
The Center for Population Options (CPO) is a nonprofit educational organization dedicated to improving the quality of life for adolescents by preventing too-early childbearing. CPO's national and international programs seek to improve adolescent decision making through life planning and sexuality education programs. As part of its mission, CPO promotes access to comprehensive health care, including family planning, through school-based and other community-based clinics and works to prevent the spread among adolescents of HIV and other sexually transmitted diseases.



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1. Introduction

The teen birthrate is a barometer that measures our society's investment in the future. Teen mothers are more likely than their childless peers to face a blighted future – to live in poverty, to receive public assistance, to be a single parent, to be a school dropout and to be unemployed. They are less likely to obtain early prenatal care,[1] and their children are at highest risk of low birth weight and further hospitalization or death in infancy.

Only slightly more than half of teenagers under 18 who become mothers finish high school,[2] and whether those dropping out of school do so before, after, or because of their pregnancy, they remain at a serious educational disadvantage for the rest of their lives. This educational deficit directly affects their economic prospects and that of their children. Moreover, the children of adolescent mothers, often growing up in single-parent households and in poverty, suffer high rates of school failure and behavioral problems.[3]

In December, 1991, the Centers for Disease Control released alarming data on teen births for 1989. 517,989 babies were born to teenagers in 1989, up from 488,941 the year before. This represents not only an increase in the number of teen births, but also an 8 percent increase in the teen birthrate, defined as the number of births per 1,000 individuals. The birthrate that year for young women under 20 was the highest it has been since 1974: 58.1 for teens 15-19 and 1.4 for teens under 15.[4]

Expressed another way, in 1989 every minute another teenager became a mother. Nearly one-fourth of these young women was giving birth for the second, third or more time. Every 46 minutes an adolescent 14 years old or younger had a child.[5]

The 1989 overall teen birthrate is nearly 15 percent higher than the historic low in 1986. After years of decline, birthrates for black teens started to climb after 1983, and those for whites turned upward soon after. One of the greatest causes for concern is that the highest increase was in birthrates among younger teens, 15-17, which have risen 19 percent since 1986.[6] Even before these increases, adolescent pregnancy rates in America were the highest among developed countries, despite similar proportions of teens who are sexually experienced.[7]

These statistics illustrate a national scandal, an indication of a failure of American society. There is broad consensus that preventing teenage pregnancy and childbearing is an important national goal. *Healthy People 2000*, the Bush Administration's health agenda for the nation*, calls for the reduction of pregnancies among adolescents under 18 by nearly one-third by the turn of the century.[8] Nevertheless, it has been enormously difficult to galvanize the political will to move forward with real solutions.

The political gridlock around issues related to adolescent sexual behavior is reflected in the failure to reauthorize Title X,[9] the only federal program devoted entirely to the prevention of unwanted pregnancy for low-income women and adolescents. It is further demonstrated by the derailment of the American Teenage Study,[10] a major, longitudinal study designed to provide information about adolescent risk-taking behavior and its relationship to other social and familial factors.

* See inside back cover for a listing of all *Healthy People 2000* Family Planning Objectives.

While Congress and the Bush Administration experience discomfort and re-election anxieties, America's teens are paying the price. For teen parents and their children, too-early childbearing can result in lost economic and educational opportunity, in short- and long-term health consequences, and in emotional and social stress. However, disadvantaged young people often remain invisible to policy-makers who must negotiate competing claims for diminishing public resources.

The Center for Population Options (CPO) has conducted a cost study for each of the last six years to translate the human realities of too-early childbearing into a form that commands the attention of leaders of every political party or ideology. This report estimates the economic impact of teen parenting: what it costs America's taxpayers to support families begun when the mother was a teenager.

Because these costs affect not just the federal government but also fall heavily on state and local jurisdictions, last year for the first time CPO estimated costs to selected states and cities. The 1992 edition of the study continues this service by reporting costs to seven states – Florida, Kansas, New Mexico, Ohio, Oregon, Vermont and Wyoming – and two cities – Baltimore and San Francisco. The report also describes a number of initiatives being taken by these states and cities to help teens avoid too-early childbearing.

While this study charts the economic costs of teen pregnancy, it addresses neither the complex socioeconomic factors contributing to the increase in teen births nor the significant personal and social costs resulting from too-early childbearing. Solutions that merely seek a rapid reduction in the bottom line – the amount spent by government – are bound to miss the mark. Any single-focus approach is unlikely to address the multiple antecedents of adolescent childbearing or to ameliorate the poverty which so often accompanies it.

CPO believes that "quick fixes" focused on short-term cost reductions are likely only to defer payment by society for a brief while, and exact payment, with interest, at a later time. Rather, investment in America's young people and in programs to help them avoid pregnancy and parenthood before they are ready will reap enormous benefits for them, their families and for all Americans. The hope is that this study will contribute to the public sense of urgency and fuel the resolve of policy-makers to find creative and realistic solutions.

2. Estimated Federal Costs of Teenage Childbearing for Fiscal Year 1990

For the past six fiscal years, CPO's "Estimates of Public Costs for Teenage Childbearing" has focused national attention on the impact of adolescent births on the nation's budget. Three sets of public costs are estimated. The first, Single Year Costs, reflects the amount the U.S. federal government spends in a single year on behalf of all families in which the first birth occurred when the mother was a teenager, even though the mother may no longer be a teenager herself.

Estimates are based on a percentage of payments from three family support programs – Aid to Families with Dependent Children (AFDC), Medicaid and Food Stamps – that are made in a given year to families that began with a teen birth. The figure, which includes direct payments to service providers and families, as well as administrative costs, is actually a conservative estimate. It does not include other public costs commonly associated with family support such as job training, housing subsidies, the Women, Infants and Children (WIC) supplemental food program, subsidized school meals, special education, foster care or day care.

In 1990, the U.S. Single Year Cost was over $25 billion, up an alarming 16 percent, or $3.5 billion, from 1989 (Tables I and II). Although a portion of the increase reflects the overall rate of inflation, most is the result of a $2.16 billion (28 percent) increase in Medicaid payments for families begun when the mother was a teenager.[11] In contrast, the federal government paid only about $30 per patient receiving contraceptives in Title X clinics in FY 1990, for a total of $111.8 million.[12] CPO estimates that if every birth to a teen mother had been delayed until the mother was in her 20s, the U.S. federal government would have saved 40 percent of the calculated expenditures, or $10.02 billion.[13]

The second set of figures, Single Birth Costs, projects the public costs over a 20 year period for a single family begun in 1990 by a teen birth. This is the average public cost for each family over the first 20 years of the child's life. A family begun by a first birth to a teenage mother in 1990 will cost the taxpayer an average of approximately $18,133 by the time that child reaches age 20 (Table III). If the birth were delayed until the mother was in her 20s, the average potential saving is $7,253.

These numbers may appear low because they represent an average cost of all first births to teens even though only one-third of families begun with a teen birth actually receive public assistance. A more realistic average amount to each family that receives public assistance after a teen birth in 1990 would be approximately three times the Single Birth Costs, or $54,399 over 20 years.

Finally, the study estimates the cost of all families begun with a teen birth in 1990 over the following 20 years – the Single Cohort Cost. This figure, calculated by multiplying the Single Birth Costs by the number of first births, represents what the U.S. federal government will spend over the next 20 years to support all the families begun in 1990 by a teen mother.

There were 394,119 first births to teens in 1989, the latest year for which data is available. The Single Cohort Cost for 1990, therefore, is $7.15 billion (Table V). This cost has risen by $2 billion since 1985 (Table VI). By delaying those births, CPO estimates the federal government could save as much as $2.86 billion over the next 20 years.

1990 Single Year Cost

TABLE I

Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births

Estimate for 1990
(in billions)

Funding Source	Total Outlay for AFDC Recipients[a]	Outlay Attributable To Teenage Childbearing[b]	Potential Savings[c]
Aid to Families with Dependent Children (AFDC)	$21.20	$11.23	$4.49
Food Stamps	$7.50	$3.98	$1.56
Medicaid	$18.57	$9.84	$3.94
TOTAL		$25.05	$10.02

[a]Based on the assumption that families begun by a teen birth consume 53 percent of these funding sources. See Methodology for further explanation.
[c]Calculated at 40 percent of full cost.

1985 - 1990 Single Year Costs

TABLE II

Six Year Trend in Single Year Costs Attributable to Teenage Childbearing

(in billions)

SINGLE YEAR COST:	1985	1986	1987	1988	1989	1990
Aid to Families with Dependent Children (AFDC)	$8.32	$9.49	$9.87	$10.07	$10.43	$11.23
Food Stamps	$3.42	$2.82	$2.97	$3.23	$3.44	$3.98
Medicaid	$4.91	$5.62	$6.43	$6.53	$7.68	$9.84
	$16.65	$17.93	$19.27	$19.83	$21.55	$25.05

1990 Single Birth Cost

TABLE III

Projected Average 20-Year Cost to Support *Each* Family Begun by a Teenager in 1990 and Potential Savings Associated with Delaying These Births[a]

Estimates over Twenty-Year Period 1990-2009

Age	Number of First Births[b]	Family Cost[c]	Average Single Potential Savings[d]
<15	11,006	$23,094	$9,237
15-17	154,244	$23,050	$9,219
18-19	228,869	$14,581	$5,834
TOTAL	394,119	$18,133	$7,253

[a]Based on AFDC, Medicaid and Food Stamp expenditures.
[b]1989 natality statistics are the latest available.
[c]Cost is expressed in 1990 "present value" dollars, which means that this is the amount that would have to be set aside in 1990 to cover the 20-year cost of the average family begun by a first birth to a teen in 1990, after taking into consideration inflation and the future earning power of a dollar invested in 1990. For Table III, "full cost" represents the total cost to support ALL of the families begun by a first birth to a teenager in 1990 (estimate based on 1989 statistics), at the average costs estimate in Table II. See Methodology for further explanation.
[d]Calculated at 40 percent of full cost.

1985 - 1990 Single Birth Cost

TABLE IV

Six Year Trend in Projected 20-Year Public Costs to Support *Each* Family Begun by a Teen Birth
(average cost)

Age	1985	1986	1987	1988	1989	1990
<15	$17,724	$18,913	$19,691	$20,723	$21,491	$23,094
15-17	$17,689	$18,897	$19,638	$20,679	$21,446	$23,050
18-19	$11,214	$11,984	$12,416	$13,101	$13,579	$14,581
All Teens	$13,902	$14,852	$15,450	$16,410	$16,975	$18,133

1990 Single Cohort Cost

TABLE V

Projected 20-Year Public Cost for *All* Families Begun by Teenagers in 1990 and Potential Savings Associated with Delaying These Births[a]

Estimates over Twenty-Year Period 1990-2009
(in billions)

Age	Full Cost[c]	Potential Savings[d]
<15	$0.25	$0.10
15-17	$3.56	$1.42
18-19	$3.34	$1.34
TOTALS	$7.15	$2.86

[a]Based on AFDC, Medicaid and Food Stamp expenditures.
[b]1989 natality statistics are the latest available.
[c]Cost is expressed in 1990 "present value" dollars, which means that this is the amount that would have to be set aside in 1990 to cover the 20-year cost of the average family begun by a first birth to a teen in 1990, after taking into consideration inflation and the future earning power of a dollar invested in 1990. For Table III, "full cost" represents the total cost to support ALL of the families begun by a first birth to a teenager in 1990 (estimate based on 1989 statistics), at the average costs estimate in Table II. See Methodology for further explanation.
[d]Calculated at 40 percent of full cost.

1985 - 1990 Single Cohort Costs

TABLE VI

Six Year Trend in Projected 20-Year Costs to Support *All* Families Begun by a Teen

(in billions)

Age	1985	1986	1987	1988	1989	1990
<15	$0.17	$0.18	$0.19	$0.21	$0.22	$0.25
15-17	$2.55	$2.73	$2.85	$3.08	$3.24	$3.56
18-19	$2.44	$2.60	$2.66	$2.69	$2.89	$3.34
All Teens	$5.16	$5.51	$5.70	$5.98	$6.35	$7.15

3. Teen Pregnancy Prevention: Imperatives for the 1990s

Since 1986, the U.S. has been losing ground in the effort to prevent teenage pregnancy and childbearing.[14] Policy initiatives have been caught up in societal ambivalence about adolescent sexual behavior, in anxieties about parental roles and in philosophical, theological and political conflicts over abortion.

The specter of AIDS has increased the urgency with which our society must come to terms with the reality of teen sexual risk-taking, but it has also escalated the anxiety surrounding teen sexual behavior. Last year the Bush Administration and Congress blocked funding for critical research that would help identify the relationship between various teen risk-taking behaviors.[15] That information would have helped us understand how to design more effective interventions to avert negative personal and social consequences, including too-early childbearing.

The last two decades have seen dramatic increases in the proportion of adolescent girls who have had sexual intercourse. By the time they reach the age of 20, three-fourths of American females and 86 percent of American males are sexually active.[16] Nearly one-third (31.9 percent) of ninth-grade girls and nearly half (48.7 percent) of ninth-grade boys report having had sexual intercourse.[17] In 1988 over half of all females 15-19 reported having had sexual intercourse, up from 28.6 percent in 1970.[18] Despite this increase, between 1970 and 1986 teen pregnancy and birthrates continued to fall due to improved access to and use of contraceptives and the legalization of abortion.

Unfortunately, our ability to deliver contraceptive services to the growing numbers of sexually active teens has not kept pace. One-third of the increase in sexually experienced teens reported since 1970 occurred between 1985 and 1988,[19] corresponding generally to the recent rise in the teen birthrate. Every year over one million teenaged women – one in ten – become pregnant. Eighty-two percent of these pregnancies are unintended,[20] and three out of five occur to teenagers not using any form of contraception.[21] By the age of 20, an estimated 43 percent of all adolescent girls will have become pregnant at least once.22 Clearly, the strategies of the last decade that have resulted in reduced access to services and alternatively rely on "just-say-no" messages have failed.

The recent increase in the teen birthrate may reflect an increase in pregnancy rates, a decrease in abortion rates or both.[23] Both family planning and abortion services are becoming more difficult for teens to obtain at a time when they need them more. Already 37 states have enacted laws limiting minors' access to confidential abortion, although not all are currently enforced.

Compounding this situation is the likelihood that *Roe v. Wade* itself will be overturned, explicitly or in effect. Undoubtedly as a result, teens in some states will lose access to abortion services altogether and more teens will become mothers. Should abortion become illegal and should all teens now choosing abortion be forced to give birth, then U.S. taxpayers could expect to pay billions more in Medicaid, AFDC and Food

Stamp costs for the additional children born to teens in any single year (Single Cohort Costs).[24]

Prevention of unintended pregnancy through use of contraceptives is always preferable to abortion. With abortion less available to teens, prevention becomes even more urgent. Furthermore, preventing teen pregnancy is extremely cost-effective. A study by the Alan Guttmacher Institute found that for every dollar of federal funds spent to provide contraceptives to women of all ages, $4.40 is saved that would otherwise be needed for medical care, welfare and nutrition programs just in the two years following a birth.[25] Yet after adjustments for inflation, the federal FY 1990 spending for contraceptives has actually decreased by over one-third since 1980. While most states have dramatically increased their own spending for contraceptive services to compensate for federal cutbacks, total federal and state spending has not kept pace with inflation.[26]

Thus, despite the potential for savings, we are investing less. As a result, fewer teens are being served by family planning clinics. Clinics are the source of contraceptive care for six out of ten teens seeking services. In 1983, family planning clinics funded with Title X funds served 1.5 million teenagers.[27] According to the Alan Guttmacher Institute, in 1988 that number had dropped to 1.1 million.[28] As many as 4.9 million of the nation's 9 million teenaged women have had sexual intercourse, and almost all are at risk of unintended pregnancy.[29] The unmet need for contraceptive services for adolescents is tremendous.

The cost of teen births is not limited to the direct assistance payments calculated in this study. Too-early childbearing represents significant medical risks for teens, particularly younger ones. This results in higher medical costs associated with pregnancy, and has an impact on the present and future health of the individual teen. During pregnancy, teenagers are at a much higher risk than older women of suffering from serious medical complications, including anemia, pregnancy-induced hypertension, toxemia, cervical trauma and premature delivery. The maternal mortality rate for mothers under age 15 is 60 percent greater than for women in their 20s.[30] Teenagers' tendency to delay or forego prenatal care contributes to the increased health risk of pregnancy. Only 54 percent of teens who gave birth in 1989 received prenatal care in the first trimester (compared to 85 percent for older women 30-34), and 14 percent received late or no prenatal care.[31]

One of the most heart-rending costs of teen pregnancy is paid by the infants themselves. According to the Children's Defense Fund, infants whose mothers received no prenatal care are 40 times more likely to die during the neonatal stage than infants born to women who received adequate prenatal care.[32] The infant mortality rate in this country is strongly related to the number of infants born at low birth weights. In 1989,

over 10 percent of babies born to teens under 18 were of low (2,500 grams or less) or very low (1,500 grams or less) birth weight.[33] While infant mortality rates have been reduced, it is because enhanced technology succeeds in saving a greater percentage of low birth weight infants. We have not succeeded in decreasing the numbers of infants born at such low weights.[34] Even normal birth weight infants of teen mothers have a higher rate of rehospitalization than infants of older mothers.[35] Lengthy hospital stays, painful procedures and greater risk of chronic illness and disability exact high personal medical costs and increase the burdens on an inadequate health care system.

Teen mothers are less likely than their childless peers to have the education and skills needed to become economically independent. Eighty percent of teen mothers drop out [36] and only 56 percent ever graduate from high school.[37] A woman who begins parenting in her teens makes half the lifetime earnings of a woman who waits until she is 20 to have her first child.[38] She is also at greater risk of living in poverty. In 1985 and 1986, 81 percent of young mothers living alone had incomes below the federal poverty level, and poverty rates even of married teen mothers were twice the national average.[39]

Two-thirds of parenting teens 15-19, and almost all teens 14 or younger, are unmarried,[40] increasing the likelihood that they will need public assistance. Any form of child support from the father is extremely rare. Only 20 percent of *all* never-married mothers are awarded child support payments, although some fathers may contribute voluntarily.41 Furthermore, in many cases of teen births the father is not identified. The age of the father is unknown more than 40 percent of the time, but where it is known, almost one-third of fathers are teenagers themselves.[42] Even if the father is older he is likely to be unskilled and/or unemployed.

In the short run, marriage appears to reduce the poverty associated with teen childbearing, since fewer married teens receive public assistance. This is misleading, however, because prior to FY 1991 two-parent families were ineligible for benefits in many states. Even when teenaged girls marry, their husbands are almost three times less likely to have completed high school, and have higher unemployment rates than their peers.[43] One survey showed that 40 percent of the husbands of these young women were not high school graduates, and are unlikely to be highly skilled or have high-paying jobs.[44] Furthermore, many of these early marriages are short-lived. Married teen mothers face higher divorce rates than women who wait until they are older to have children.[45]

Over 90 percent of teens who choose to carry a pregnancy to term also choose to raise the child themselves. Teens who parent are suddenly faced with the awesome responsibility of shaping the lives and characters of their children, at a time when they themselves are in the midst of overwhelming and confusing physical and emotional developmental tasks. Too often teen parents have little or no social support system. Not only is their own development interrupted by parenthood, but that of their children is all too often negatively affected as well.

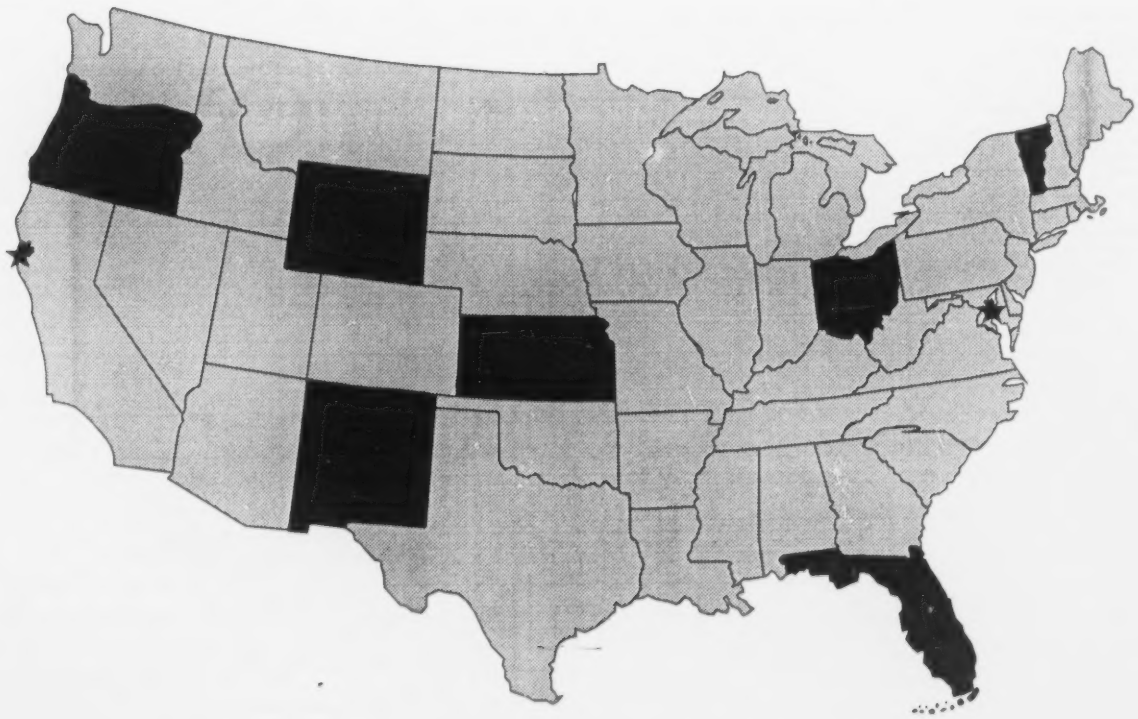
Guiding the growth and development of the next generation and passing on the collective wisdom of the culture is one of the most important tasks of any society. We owe a productive and healthy future to all our children. Education and services can help teens prevent births until they are ready. This report describes many of the programs being implemented in states and cities to prevent too-early childbearing and assist parenting teens – both young women and young men – to achieve brighter futures for themselves and their children. But these and other efforts must overcome lack of funds, political agendas and years of counterproductive policies. The need to reduce the heavy burden on taxpayers from too-early childbearing must move policy-makers to adopt policies that are effective in reducing teen births and reject those that do not work.

4. Teenage Childbearing: Seven States and Two Cities

Teenage pregnancy exacts a toll at the state and local levels as well as the national level. This section includes cost estimates for Florida, Kansas, New Mexico, Ohio, Oregon, Vermont, Wyoming and the cities of Baltimore and San Francisco. The number calculated for each jurisdiction is an estimate of the Single Year Cost – the local equivalent of the $25.05 billion that the Federal government spends each year to support families begun when the mother was a teenager. This cost for the states and cities includes both what local governments spent on AFDC, Food Stamps and Medicaid and the portion of federal funding received by the states for these programs. Thus, the total figures for each state and city reported in this section represent those locales' allocations of federal funds, part of the $25.05 billion described earlier, as well as other monies originating from state and local revenues. Most city governments do not fund Medicaid services directly. A local contribution to the non-feceral portion of Medicaid, when required by the state plan, is more often provided by counties than by cities. The two cities highlighted here, however, are examples of city-county consolidations that do provide Medicaid services.

Although these nine geographically diverse localities are not representative of all communities in the United States, they do provide an idea of the broad range of costs of too-early childbearing to states and cities. Bear in mind that AFDC, Medicaid and Food Stamp payments vary from state to state. Therefore, a local jurisdiction providing payments that are at a higher percent of poverty level than another jurisdiction will have higher costs associated with teen childbearing, but will also be providing more completely for those families in need.

Accompanying the states' and cities' Single Year Cost estimates are statistics about adolescent pregnancy and birth as well as descriptions of pregnancy prevention efforts in each area. Unless the state provided more recent teen pregnancy or birthrates, 1985 data is cited. Increases in family planning appropriations occurred in 1990 in every one of the states highlighted. Most of the states and cities described have a governor's or mayor's task force on adolescent pregnancy; a range of recommended strategies have emerged from these bodies. Some common themes – early intervention, male involvement, increased access to contraceptive services, job skills training, family life education – are echoed, suggesting that there is some consensus as to how to confront the problem. Unusual or innovative programs described – shopping mall clinics, teen parents as peer counselors, mentoring, media campaigns, hotlines, parent/teen forums – might point the way to future activities. While not comprehensive, the narratives do provide useful information about the range of approaches brought to bear to reduce the incidence of too-early childbearing in disparate communities.



Teenage Pregnancy In Florida

Florida's teen pregnancy rate of 126 per 1,000 15- to 19-year-old girls is the sixth highest in the United States. The state's teen birthrate of 58 per 1,000 ranks 14th highest in the nation. For white teens in the same age group, Florida's birthrate of 43 per 1,000 ranks 26th; for "nonwhite" teens, the birthrate is 114 per 1,000, ranking fourth highest in the U.S.[46]

In 1985, 12.6 percent of young women 15-19 in Florida became pregnant, compared with 11.0 percent nationwide. Of all births to teens in Florida in 1988, 74.4 percent were first births; 25.6 percent were second or later births. In the same year, girls 14 and younger had 713 babies in Florida. [47] Teenagers account for nearly one-third of all unintended pregnancies in the state. [48]

The 1989 session of the Florida Legislature amended the Florida Employment Opportunity Act, directing the Department of Health and Rehabilitative Services, in cooperation with the Department of Education, to prepare and submit a report on teen pregnancy by October, 1990. In response to report findings, the two departments developed recommendations and strategies designed to prevent teen pregnancy and reduce the serious consequences of teen parenthood. [49]

The report states that current programs and services addressing Florida's teen pregnancy problem are generally appropriate in terms of the nature of the services being provided and the needs of those they are intended to serve. Lack of adequate resources, however, means that most agencies and programs do not have the resources needed to provide an adequate level of service to all teens needing assistance, or in all areas of the state.[50]

The Department of Health and Rehabilitative Services provided 49,679 teens with family planning services in 1988-89 at an estimated savings of $128 million in public assistance costs. The Department of Education's comprehensive health education and substance abuse policy requires that all public and laboratory schools provide instruction in reproductive health, HIV/AIDS, interpersonal skills and parenting to reduce teen pregnancy and promote healthy behavior for all students in grades K-12, beginning with the 1991-92 school year. [51]

Expansion of school health clinics, through a law passed in the 1990 legislative session, helps provide adolescents with the preventive health care services they need in an accessible place. The services include education and counseling regarding risk-taking behaviors, HIV and other sexually transmitted diseases, drug abuse and family planning issues. Even with the expansion, however, limited funds will mean that close to two million Florida students a year will still be in need of comprehensive school health services. [52]

Florida is promoting male involvement in pregnancy prevention through two demonstration projects. The first, the Leadership for Young Men Program is a rural project, at the high school in the town of Century. The goals of the eight-week program

are to empower young men to plan a future and to help them develop the motivation to delay sexual activity. The program emphasizes job readiness skills, vocational and academic training, counseling, health education and self-esteem building. Some participants are paid a $5 weekly stipend for their attendance.

The second, Project First Class, is an urban project, located in four middle schools in Broward County. The program emphasizes human sexuality, postponing sexual involvement, values clarification, AIDS awareness, self-esteem building, counseling and information/referral. The program is designed to develop decision-making skills through group counseling/rap sessions. Each participant is paired with an older male who has completed previous leadership programs. No stipends are paid.[53]

A project targeting teenage girls, Brighter Futures Club, operates in three Florida counties. Participants are girls who have previously been pregnant. They are paid a stipend of $1 a day to remain in school and not become pregnant. The positive peer support and pressure generated through weekly club meetings, together with the spontaneous counseling that occurs, is expected to help girls delay future pregnancies until they have completed school or vocational training. [54]

Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births in Florida

Estimate for 1990
(in millions)

Funding Source	Total Outlay for AFDC Recipients[a]	Outlay Attributable To Teenage Childbearing[b]	Potential Savings[c]
Aid to Families with Dependent Children (AFDC)[d]	$568.07	$301.08	$120.43
Food Stamps[d]	$375.21	$198.87	$79.59
Medicaid	$588.40	$295.95	$118.38
TOTAL		**$795.90**	**$318.40**

[a]Includes administrative costs.
[b]Based on the assumption that families begun by a teen birth consume 53 percent of these funding sources. See Methodology for further explanation.
[c]Calculated at 40 percent of full cost.
[d] AFDC and Food Stamp benefits as percent of poverty in 1990 in Florida: 62.4 percent (Center for the Study of Social Policy, Kids Count Data Book, [Washington, D.C.: 1992])

Teenage Pregnancy in Kansas

The 1990 teen pregnancy rate in Kansas is 35.1 per 1,000 females 10-19, the highest rate for that age group in Kansas since 1983. For girls 10-14, the pregnancy rate is 1.1; for young women 15-19, the rate is 70.5 for 1990. In that same year, 80.8 percent of live births to teen mothers were to white mothers; 17.2 percent were to black teen mothers and 2 percent were to races listed as "other." In 1990, 4,758 babies were born to mothers age 10-19, representing 12.24 percent of all live births in Kansas. [55]

The state's teen birthrate of 49 per 1,000 ranks 26th highest in the nation. For white teens in the same age group, Kansas' birthrate of 44 per 1,000 ranks 22nd highest; for "nonwhite" teens, the birthrate is 99 per 1,000, which ranks 13th highest. [56]

In 1987, the Kansas State Board of Education mandated human sexuality/AIDS education in grades K-12; beginning in 1988, the Kansas Legislature provided $1.5 million per year to help fund the mandate. Also in 1988, the legislature funded for the first time a school-linked health clinic for teens, located in Wichita. Beginning in 1989, the legislature provided $2.25 million per year for programs targeting youth in risky situations, including those at risk of becoming teen parents.

In fiscal year 1992, the state plans to open two pilot projects, in Winfield and Topeka, designed to focus on young people 10-17 and their parents. The emphasis will be on improving parent-child communication, building self-esteem and promoting abstinence. Each project is required to provide contraceptive information to those who ask for or need it. Specially trained community volunteers will assist program participants in: recognizing the value and importance of postponing sexual intercourse; developing knowledge and attitudes which promote comfort in choosing not to participate in sexual intercourse; preventing pregnancy by choosing appropriate methods of contraception if they choose to be sexually active; recognizing the personal, parental, familial, religious, legal, social and health consequences of irresponsible sexual behavior; developing assertiveness skills to resist pressure from peers and society to be sexually active; improving self-concept and developing responsible behavior based on family values; and fostering communication within the family. [57]

A private statewide program to prevent teenage pregnancy in Kansas was developed and carried out from October 1987 to September 1989 by Kansas Action for Children. The major elements of this public awareness campaign included: 5,000 posters, 170 billboard messages ("Sex Education: Children Need to Know, Parents Need to Tell Them" and "Last Year, 4,490 Babies Were Born to Kansas Teens. Help Teens Delay Parenthood"), a mass transit campaign ("Love is Great, Sex Can Wait"), teen parent speakers panels, rap songs on radio, ads in high school newspapers, radio public service announcements featuring the Oak Ridge Boys, public service announcements in 60 movie theaters and an ongoing networking newsletter, *Kansas Adolescent Concerns*. [58]

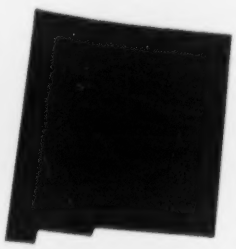
Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births in Kansas

Estimate for 1990
(in millions)

Funding Source	Total Outlay for AFDC Recipients[a]	Outlay Attributable To Teenage Childbearing[b]	Potential Savings[c]
Aid to Families with Dependent Children (AFDC)[d]	$120.76	$64.00	$25.60
Food Stamps[d]	$48.07	$25.48	$10.19
Medicaid	$45.84	$24.29	$ 9.72
TOTAL		$113.77	$45.51

[a]Includes administrative costs.
[b]Based on the assumption that families begun by a teen birth consume 53 percent of these funding sources. See Methodology for further explanation.
[c]Calculated at 40 percent of full cost.
[d] AFDC and Food Stamp benefits as percent of poverty in 1990 in Kansas: 72.04 percent (Center for the Study of Social Policy, Kids Count Data Book, [Washington, D.C.: 1992])

Teenage Pregnancy in New Mexico



New Mexico's teen pregnancy rate of 116 per 1,000 15- to 19-year-old girls is the 11th highest in the United States. Its teen birthrate of 70 per 1,000 ranks fifth in the nation. [59] In 1985, 11.6 percent of young women in New Mexico 15-19 became pregnant, compared with 11.0 percent nationwide. Of all births to teens in New Mexico in 1988, 75.6 percent were first births; 24.4 percent were second or later births. In 1988, 63 babies were born to teens 14 and younger in New Mexico. [60]

In the same year, 1988, 12.5 percent of all births in the U.S. were to teen women, but in New Mexico 15.7 percent of all births were to teen mothers. In response to the growing number of teen births, in 1988 the governor established the Governor's Task Force on Adolescent Pregnancy to make policy and program recommendations to the Governor in critical areas, including community and school education, and health and social services based on identification of needs and possible ways to reduce teenage pregnancy. That task force became the Governor's Advisory Committee on Adolescent Pregnancy in 1991, when a new administration entered office. The statewide pregnancy prevention plan is being updated as a result.

The Office of Adolescent Pregnancy Prevention was established in response to one of the legislative initiatives recommended by the original task force. Charged with acting as a liaison between local and state agencies and as a clearinghouse for information and activities, the office also allocates seed money for prevention projects around the state. In 1991, 13 projects were funded, each with a strong evaluation component. One-half of the projects are designed for already-pregnant and parenting teens, while the other half focus on preventing the first unwanted teen pregnancy. The latter involve a variety of innovative approaches, including mentorship programs and parent awareness projects aimed at improving parent-child communication.

The office is also responsible for developing public awareness of the adolescent pregnancy situation in New Mexico. As a result, between the fall of 1990 and the spring of 1991, a statewide radio campaign was mounted. Eight different types of public service announcements were broadcast, most of which focused on the importance of parent-child communication in the delivery of messages about delaying sexual activity and parenthood. In addition, thousands of flyers titled "How Safe Are You? Check Your Sexual IQ" were distributed to students in most New Mexico public high schools. The flyers highlighted facts about HIV, other sexually transmitted diseases and teen pregnancy.

New Mexico is among 23 states that mandate sexuality education in all schools. The Family Life Education plan is being updated. [61]

Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births in New Mexico

Estimate for 1990
(in millions)

Funding Source	Total Outlay for AFDC Recipients[a]	Outlay Attributable To Teenage Childbearing[b]	Potential Savings[c]
Aid to Families with Dependent Children (AFDC)[d]	$70.24	$37.23	$14.89
Food Stamps[d]	$33.89	$19.53	$7.81
Medicaid	$64.06	$31.22	$12.49
TOTAL		**$87.98**	**$35.19**

[a]Includes administrative costs.
[b]Based on the assumption that families begun by a teen birth consume 53 percent of these funding sources. See Methodology for further explanation.
[c]Calculated at 40 percent of full cost.
[d] AFDC and Food Stamp benefits as percent of poverty in 1990 in New Mexico: 62.4 percent (Center for the Study of Social Policy, Kids Count Data Book, [Washington, D.C.: 1992])

Teenage Pregnancy in Ohio

Ohio's teen pregnancy rate of 96 per 1,000 15- to 19-year-old girls is the 29th highest in the nation. The state's teen birthrate of 50 per 1,000 places Ohio 24th highest in the United States. For white teens in the same age group of 15- to 19-year-olds, Ohio's birthrate of 43 per 1,000 ranks the state 27th highest; for "nonwhite" teens, the birthrate is 93 per 1,000, ranking Ohio 19th highest in the U.S.[62]

In 1985, 9.6 percent of young women 15-19 in Ohio became pregnant, compared with 11.0 percent nationwide. Of all births to teens in Ohio in 1988, 77.3 percent were first births; 22.7 percent were second or later births. In 1988, teens 14 and younger had 405 babies in Ohio. [63]

In 1986, the Governor's Task Force on Adolescent Sexuality and Pregnancy issued its final report, complete with a description of the teen pregnancy situation in Ohio, a list of services already provided to teens and recommendations for further action. The report states firmly that mitigation of Ohio's teen pregnancy crisis requires programs that reach beyond the individual pregnant adolescent and instead involve those who influence the lives of adolescents and that confront the economic and social realities of teens, displaying sensitivity to cultural differences. The recommendations of the task force include: establishing joint state-local funding to provide financial support to those programs that encourage the postponement of sexual activity among teens and to help prevent teenage pregnancy; requiring all school districts to offer K-12 human growth and development education; targeting resources for youth in risky situations to help them train for and secure employment; and appropriating $400,000 a year in public funds toward a teen pregnancy and sexuality public education/awareness campaign. [64]

Teen Decisions, a statewide public awareness campaign targeted at children between the ages of 10 and 14, was launched in September, 1990 and ran through April, 1991. The campaign message was "Your decisions about sex change your life – forever". The Teen Decisions message was delivered throughout Ohio on radio and television commercials and public service announcements, on posters and other printed materials as well as on movie theater slides.

Media and printed materials promoted a toll-free hotline number. The two minute pre-recorded message asked callers to leave their name, address, city, state, zip code and where they heard about the hotline in order to receive an informational brochure. Between September 10, 1990 and April 23, 1991, 126,144 calls were made to the hotline. Of this number, 22,141 calls resulted in recorded requests for information. The overwhelming response to the hotline exhausted all project funds, revealing a hunger for information about preventing teen pregnancy. [65]

In addition, large metropolitan areas such as Cleveland, Cincinnati, Columbus, Dayton, Akron and Toledo have founded consortia, coalitions and networks that enable program providers to work cooperatively. Several innovative efforts to reduce teen pregnancy have been undertaken in these communities; the most successful are those programs utilizing a peer-to-peer discussion approach to teenage sexuality, pregnancy and parenting. [66]

Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births in Ohio

Estimate for 1990
(in millions)

Funding Source	Total Outlay for AFDC Recipients[a]	Outlay Attributable To Teenage Childbearing[b]	Potential Savings[c]
Aid to Families with Dependent Children (AFDC)[d]	$981.83	$427.10	$170.84
Food Stamps[d]	$625.13	$271.93	$108.77
Medicaid	$695.25	$302.43	$120.97
TOTAL		$1,001.46	$400.58

[a]Includes administrative costs.
[b]Based on the assumption that families begun by a teen birth consume 43.5 percent of these funding sources. See Methodology for further explanation.
[c]Calculated at 40 percent of full cost.
[d] AFDC and Food Stamp benefits as percent of poverty in 1990 in Ohio: 67.3 percent (Center for the Study of Social Policy, Kids Count Data Book, [Washington, D.C.: 1992])

Teenage Pregnancy in Oregon

The teen pregnancy rate per 1,000 15- to 19-year-old girls in Oregon in 1989 is 82.3. In 1989, there were at least 8,152 pregnancies to Oregon women under 20 years of age, a 3.9 percent increase over 1988. There were 132 pregnancies to girls under 15 in 1989 in the state. In that year, there were 4,918 births to mothers under 20, an increase of 8.0 percent over the preceding year. The teen birthrate is 49.8 per 1,000 young women under 20. [67]

In 1989, House Bill 3114 was enacted by the Oregon Legislature, requiring that the Committee on Adolescent Pregnancy and Parenthood be established to provide recommendations on the implementation of public policies and a statewide comprehensive program to combat the problem of adolescent pregnancy. The committee released its first report in July, 1990 and its final report in January, 1991.

The five specific recommendations to reduce adolescent pregnancies include: ensure that family planning information and services are available to adolescents in all areas of the state; continue and expand school-based clinic programs which provide comprehensive health care as well as reproductive health services; fund six pregnancy prevention pilot projects which replicate proven prevention models targeting students at risk in late elementary and early middle school levels; develop comprehensive family life education demonstration programs in geographically diverse areas of the state; and create a public education initiative to increase public understanding of issues related to adolescent childbearing. The final report also called for the establishment of an Office of Adolescent Pregnancy and Parenthood to provide leadership, coordination and focus to the statewide teen pregnancy prevention effort. [68] All of the recommendations of the committee were proposed as legislation in 1991, but for the most part no action was taken on any of them.

In 1991, Oregon became the first state to adopt in statute a set of measurable objectives designed as part of a 20 year strategic vision for the state. Termed the "Oregon Benchmarks," the 160 goals range from reducing the number of drug-affected babies to improving air quality. Five "human investment" benchmarks were named as top priorities to be achieved in the next five years, based on the understanding that achievement of some benchmarks must precede others to realize a particular objective.

One of these "lead" benchmarks is reducing teen pregnancy from a rate of 19.5 per 1,000 females 10-17 in 1990 to 9.8 in 1995. Achieving this benchmark has now become the focus of Oregon's efforts in the area of teen pregnancy prevention. The state has directed $1 million in state general funds for the next two years to adolescent pregnancy prevention and family planning service improvement. This funding has enabled the Health Division to hire an Adolescent Pregnancy Prevention Coordinator and has provided funds for expanding the capacity of local family planning clinics as well as providing community education and outreach activities. [69]

Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births in Oregon

Estimate for 1990
(in millions)

Funding Source	Total Outlay for AFDC Recipients[a]	Outlay Attributable To Teenage Childbearing[b]	Potential Savings[c]
Aid to Families with Dependent Children (AFDC)[d]	$187.20	$91.73	$36.69
Food Stamps[d]	$59.95	$29.38	$11.75
Medicaid	$64.95	$31.83	$12.73
TOTAL		$152.94	$61.17

[a]Includes administrative costs.
[b]Based on the assumption that families begun by a teen birth consume 49 percent of these funding sources. See Methodology for further explanation.
[c]Calculated at 40 percent of full cost.
[d] AFDC and Food Stamp benefits as percent of poverty in 1990 in Oregon: 78.8 percent (Center for the Study of Social Policy, Kids Count Data Book, [Washington, D.C.: 1992])

Teenage Pregnancy in Vermont

Among 15- to 19-year-old women in Vermont, the pregnancy rate is 82 per 1,000, the 41st highest of all states. Although this rate is among the lowest in the nation, teenage childbearing is an issue of concern for Vermont. Of all mothers in Vermont having their first child in 1988, 17.2 percent were teenagers, a percentage higher than average. Of all births to teens in Vermont in 1988, 81.2 percent were first births and 18.8 percent were second or later births. The state's 8.9 percent of young women age 15-19 who became pregnant compares favorably with 11.0 percent nationwide for 1985.[70] According to Vermont's most recent report of the Governor's Task Force for Prevention of Teen Pregnancy, however, one in 25 teenage girls 15-17 becomes pregnant each year and the babies of teenage mothers continue to have a significantly higher mortality rate than babies of older mothers.[71]

In 1986, a statewide grassroots effort resulted in the creation of the Governor's Task Force for the Prevention of Teenage Pregnancy. Vermont's concerted effort to reduce too-early childbearing among adolescents has focused on the set of goals outlined by that task force. They include: reducing the pregnancy and birthrates among 15- to 17-year-olds; reducing repeat teen births; preventing all pregnancies to girls under 15; ensuring that all adolescents complete high school; and ensuring that 90 percent of teens receive prenatal care beginning in their first trimester, to reduce low birthweight and infant mortality among babies born to teen mothers.[72]

Specific efforts to combat teen pregnancy include providing outreach and family planning services to teens through Planned Parenthood of Northern New England and continued funding of the Teen Pregnancy Initiative, a community-based program designed to prevent second and third births to teenagers.[73]

In addition, communities throughout the state have formed Parent/Teen Forums and Teen Advisory Boards to identify and promote services for teens and to support the development of family life school curricula. Vermont mandates sexuality education; in 1988 the state legislature passed an act requiring that all schools provide age-appropriate, comprehensive health education – including information on contraception – to grades K-12. Lastly, Vermont is working to prevent school dropout and improve youth employment and training programs in an effort to help teens improve their life chances.[74]

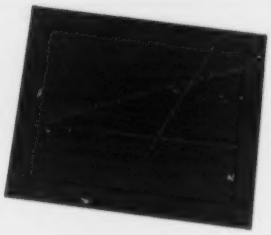
Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births in Vermont

Estimate for 1990
(in millions)

Funding Source	Total Outlay for AFDC Recipients[a]	Outlay Attributable To Teenage Childbearing[b]	Potential Savings[c]
Aid to Families with Dependent Children (AFDC)[d]	$50.16	$26.59	$10.64
Food Stamps[d]	$15.77	$8.36	$3.34
Medicaid	$12.97	$6.88	$2.75
TOTAL		$41.83	$16.73

[a]Includes administrative costs.
[b]Based on the assumption that families begun by a teen birth consume 53 percent of these funding sources. See Methodology for further explanation.
[c]Calculated at 40 percent of full cost.
[d]AFDC and Food Stamp benefits as percent of poverty in 1990 in Vermont: 88.7 percent (Center for the Study of Social Policy, Kids Count Data Book, [Washington, D.C.: 1992])

Teenage Pregnancy in Wyoming



Wyoming has the 27th highest pregnancy rate in the nation with 98 pregnancies per 1,000 15- to 19-year-old girls. The state's teen birthrate for the same age group is 54 per 1,000, which places Wyoming 18th overall in the United States. [75] Of all births to teens in Wyoming in 1988, 80.4 percent were first births and 19.6 percent were second or later births. In the same year, teens 14 and younger in Wyoming had four babies. In 1985, 9.8 percent of young Wyoming women 15-19 became pregnant, which is less than the entire country's 11 percent. [76]

The Governor's Pregnancy Task Force, established in 1986, adopted six priorities in 1991. They are: pursue comprehensive health education for grades K-12 in all school districts and as a requirement for graduation; expand and advocate confidential, quality, judgement-free reproductive health services; educate legislators to the problems and costs of teen pregnancy and low-birth weight babies; encourage development of case management and mentoring programs as a means of reducing second and subsequent teen pregnancies; expand availability and use of quality counseling for pregnant and parenting teens and those considering sexual activity, including peer counseling; and research the impact of Wyoming's parental consent statute on abortion. [77]

The state of Wyoming is one of the few states in the U.S. to have no position on sexuality education.[78] Since local school districts have control over whether to offer family life education, the task force is working with individual communities to promote the idea that comprehensive sexuality education is necessary to lower the teen birthrate. The task force is working to educate the state legislature on the issue as well. A 45-member committee on comprehensive school health education standards is developing standards that school districts can use as a guideline for what to incorporate into their plans. Once the standards are established, training will be implemented around the state.

The Wyoming Reproductive Health Council has focused recently on coordinating statewide family planning services; two years ago 10 counties in Wyoming had no services, but the Council's work has resulted in all counties being served.

The task force is working actively to establish case management and mentoring projects aimed at reducing repeat pregnancies among teens. The Department of Health administers the pilot Best Beginnings program in Albany City which works with teen mothers.

One of the goals of the Wyoming HIV/AIDS School Education Project is to expand peer counseling and peer education projects across the state, recognizing that often the best teachers for adolescents are other adolescents. [79]

Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births in Wyoming

Estimate for 1990
(in millions)

Funding Source	Total Outlay for AFDC Recipients[a]	Outlay Attributable To Teenage Childbearing[b]	Potential Savings[c]
Aid to Families with Dependent Children (AFDC)[d]	$21.70	$11.50	$4.60
Food Stamps[d]	$15.22	$8.06	$3.22
Medicaid	$13.95	$7.39	$2.96
TOTAL		$26.95	$10.78

[a]Includes administrative costs.
[b]Based on the assumption that families begun by a teen birth consume 53 percent of these funding sources. See Methodology for further explanation.
[c]Calculated at 40 percent of full cost.
[c]Calculated at 40 percent of full cost.
[d] AFDC and Food Stamp benefits as percent of poverty in 1990 in Wyoming: 65.3 percent (Center for the Study of Social Policy, Kids Count Data Book, [Washington, D.C.: 1992])

Teenage Pregnancy in Baltimore

The city of Baltimore has one of the highest adolescent birthrates for a city of its size in the U.S. During the early 1980s the percentage of births to teenagers was higher in Baltimore than in any other major city in the U.S. [80] For state fiscal year 1989, Baltimore's pregnancy rate for young women 15-17 was 141 per 1,000, as compared to 65 per 1,000 for the state of Maryland. The birthrate for Baltimore for the same age group was 87; for Maryland, 34.4.[81] In 1988, almost one-quarter of all births in Baltimore were to mothers under 20 (23 percent).[82]

The Mayor's Council on Adolescent Pregnancy Prevention, established after a 1985 task force report, was charged with developing an action plan to address the high rates of teenage pregnancy and childbirth in Baltimore. The council, composed of community leaders, devised the five point Baltimore City Strategy that focuses on early intervention, postponement of the onset of sexual activity, helping young people say no to further sexual intercourse, increasing and improving contraceptive use and providing prenatal care to adolescents along with counseling to prevent further unwanted pregnancies. Baltimore's Office of Adolescent Pregnancy Prevention and Coordination works to develop and coordinate initiatives around those five goals. The office's mission includes promotion of quality family life in addition to the prevention of adolescent pregnancy.[83]

The Healthy Teens and Young Adults Program represents the city's commitment to treating the seemingly intractable problem of adolescent pregnancy and childbearing in the neighborhoods experiencing the highest rates of both. Family planning services, outreach, education and counseling are aimed at sexually active young men and women 15-24. Education and counseling are aimed at 10- to 19-year-old males and females who are not sexually active. Community participation, agency collaboration/coordination and expansion of existing programs are bywords of the initiative, which focuses on reducing the teen birthrate, reducing the rate of second births to teens and reducing the birthrate of unmarried women 20-24.[84]

Acknowledging that males have been largely ignored in previous attempts to lower teenage pregnancy rates, the Healthy Teens and Young Adults Program includes a Male Enrichment and Outreach Project to serve three groups of black males between the ages of eight and 26. The primary goal of the project will be to provide male adolescents and mature adults with an enrichment and support program that responds to daily issues and concerns and to reduce premature and irresponsible fathering.[85]

Since March, 1990 a principal component of the Healthy Teens and Young Adults Program – a comprehensive, "privatized" reproductive health center for teens – has been operating at Mondawmin Mall, a popular gathering place for adolescents and young adults. In addition to providing comprehensive health services, the Young People's Health Connection hosts social and cultural activities designed to draw young people in for the range of services offered. An advantage to the mall-based approach is that it attracts all youth, both those enrolled in school and those who are not.[86] Baltimore also boasts eight school-based clinics that provide services to in-school youth.

Baltimore's several Family Support Centers have programs designed to prevent repeat pregnancies among teen mothers. Staff at these state-funded centers work with the young women on developing good parenting and life skills, with the intent of empowering them to delay further childbearing until educational or vocational goals have been met. [87]

The Teen Impact Program Series (TIPS), a program of the Baltimore City Health Department, is a six week, six session educational program that was implemented in three middle and three high schools in 1990. TIPS covers a range of topics connected to teenage pregnancy, including: puberty and reproduction; self-esteem; decision making; values clarification; contraception; sexually transmitted diseases; and resources for teens in crisis. [88]

Approximately 30 Parents and Children Talking (PACT) events took place in Baltimore in October, 1991. These state-funded events were offered free to parents to help them polish their skills as effective primary sex educators of their children.[89]

Lastly, an abstinence-based media program, Campaign for Our Children, resulted in a blitz of television and radio public service announcements, billboards, public transportation ads and posters designed to drive home the message of abstinence to middle-school children. Some schools reinforced the campaign's message through a month of special activities.[90]

Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births in Baltimore

Estimate for 1990
(in millions)

Funding Source	Total Outlay for AFDC Recipients[a]	Outlay Attributable To Teenage Childbearing[b]	Potential Savings[c]
Aid to Families with Dependent Children (AFDC)	$176.69	$123.68	$49.47
Food Stamps	$65.91	$46.14	$18.46
Medicaid	$108.70	$76.09	$30.44
TOTAL		**$245.91**	**$98.37**

[a]Includes administrative costs.
[b]Based on the assumption that families begun by a teen birth consume 70 percent of these funding sources. See Methodology for further explanation.
[c]Calculated at 40 percent of full cost.

Teenage Pregnancy in San Francisco

In 1989, California's teen birthrate was more than 10 percent higher than the national average, and while the national teen birthrate has remained fairly constant, California's has been steadily increasing. San Francisco is in the fortunate position of having a lower teen birthrate than the whole state. For example, in 1989 there were 54.3 births per 1,000 young women 15-19 in San Francisco, as compared to a rate of 66.4 in California.[91] In 1988, eight percent of all births in San Francisco were to teen mothers under 20, as compared to 12 percent for Los Angeles, 10 percent for San Diego, 16 percent for Bakersfield, 15 percent for Stockton and six percent for Long Beach.[92]

An innovative pregnancy prevention effort in San Francisco involves parenting adolescents as peer counselors and trainers working with youth to prevent teenage pregnancy. The University of California, San Francisco, Teen Peer Counselors Program was begun in 1990 with private foundation funds. Young parents between the ages of 17 and 20, undergo a comprehensive, 32 hour training program that equips them with sexuality knowledge and counseling skills. They then visit both middle and high schools, for several days in a row, covering the topics of birth control methods, sexually transmitted diseases and the consequences of teen parenting. The teen parents also work at the teen clinic of San Francisco General Hospital, meeting clients and guiding them through the clinic experience, as well as providing one-on-one contraceptive counseling. The teen parents work between 20 and 30 hours a week in the program and are paid.[93]

The Teen Pregnancy and Parenting Project (TAPP) of the Family Service Agency of San Francisco provides comprehensive health, educational and support services for pregnant and parenting teens. One of the major goals of this interagency citywide comprehensive case management service is to reduce the incidence of unwanted repeat births among teens. Teen parents, both male and female, benefit from the network of services put together for them by their TAPP case managers.[94]

Balboa High School in San Francisco has a school-based clinic that provides pregnancy tests, contraceptive counseling and referrals for contraceptives, among other health care services such as sports physicals. The clinic, open five days a week before, during and after the school day, serves close to 1,000 users, 55 percent of whom are male.[95] CPO's own research on school-based clinics has revealed that significantly more Balboa students used some type of contraception at last intercourse after the clinic started than before it was in place.[96]

Single Year Public Cost for All Families Started by a Teen Birth and Potential Savings Associated with Delaying These Births in San Francisco

Estimate for 1990
(in millions)

Funding Source	Total Outlay for AFDC Recipients[a]	Outlay Attributable To Teenage Childbearing[b]	Potential Savings[c]
Aid to Families with Dependent Children (AFDC)	$87.31	$46.28	$18.51
Food Stamps	$19.43	$10.29	$4.12
Medicaid	$12.83	$6.79	$2.72
TOTAL		$63.36	$25.35

[a]Includes administrative costs.
[b]Based on the assumption that families begun by a teen birth consume 53 percent of these funding sources. See Methodology for further explanation.
[c]Calculated at 40 percent of full cost.

5. Methodology

Calculating the Cost

The cost of teenage childbearing has been conceptualized in three different ways. The first is in terms of expenditures in a given year: Single Year Cost. This figure answers the question, "In 1990, how much did the Federal government spend on families begun when the mothers were teenagers?" This includes public outlays for families currently headed by teenage mothers and also those in which the mother is now 20 years of age or older, but had her first child when she was still in her teens. Although the vast majority of AFDC families have a single, female head-of-household, CPO calculations do not distinguish between married and unmarried teen mothers.

CPO includes three forms of public assistance in the calculation of the Single Year Costs: Aid for Families with Dependent Children (AFDC), Medicaid and Food Stamps. The dollar value includes both direct payments to individuals, as well as the administrative and service costs of these programs. Costs of social service programs for young mothers, special education, foster care and public housing subsidies are not included in the Single Year Cost. Though some of these expenditures are clearly attributable to teenage childbearing, estimating the dollar amounts on a national level for all families begun by a teen birth is not feasible.

The second type of cost is the projected cost over 20 years of a single teen birth in a given year: Single Birth Costs. This figure answers the question, "How much will a family begun in 1990 by a teen birth cost the public by the time that first baby is 20 years old?" This number may appear low because it is an average cost based on the total estimated number of first births to all teen mothers in 1990. Because approximately one-third of teenage mothers receive public assistance, the actual cost for a family requiring public assistance and begun by a teen birth in 1990 will be about three times this estimated average cost.

The Single Birth Costs are adjusted to reflect two important trends. First, the probability of receiving public assistance decreases over a teen mother's lifetime. The probability that a teen mother will receive welfare is one in three (.34) and the average length of time a woman who begins her family as a teen receives that assistance is 2.5 years. By the time a teen mother is 30 years old, the probability that she will still be receiving public assistance decreases to less than three in one hundred (.03).

Second, those who begin childbearing earlier in their teen years are likely to have more children than those who delay childbearing. Teens who have their first child before age 18 will have, on average, 3.2 children by age 32. Those who delay childbearing until they are 18 or 19 years old will have an average of 2.8 children by the time they reach age 32. These estimates are important in projecting the number of family members eligible for benefits and future medical expenses associated with pregnancy and childbearing.

The third type of cost calculated is the projected 20 year cost of all first children born to teens in a given year: Single Cohort Costs. In this case we are answering the

question, "How much will all the families begun by a teen birth in 1990 cost by the time those first babies are 20 years old?" This is calculated by multiplying the Single Birth Costs for 1990 by the total number of first births to teens in that year. For both Single Birth Costs and Single Cohort Cost estimates, social service and public housing costs are included, in addition to AFDC, Medicaid and Food Stamp costs used to calculate Single Year Costs.

For all the public costs calculated, an estimate is made of the potential savings to the public had there been no births to teenagers in 1990, or in other words, what we might still expect to spend had all those teen births been prevented. The potential savings are lower than the public costs in each case because delaying childbearing until age 20 or older does not guarantee that a woman will never need to receive public assistance. Because many of the women who become teenage mothers are already at a higher risk of needing financial assistance as an adult, many of the costs included in these calculations would be reduced by eliminating teenage births, but they could not be eliminated entirely. Previous research into public costs of teenage childbearing estimated a savings rate of 20 percent for reducing teenage births by half. Thus, CPO determines potential savings of delaying 100 percent of teen births by figuring 40 percent of the calculated public costs.

Determining Public Outlays

The cost of AFDC payments attributable to families begun by teen births is calculated as 53 percent of the total AFDC payments made in 1990. This estimate is based on extensive computer simulations, with a variety of databases, that resulted in a range of 50 percent to 56 percent of total AFCD expenditures. CPO settled on the midpoint of 53 percent for the purposes of this study, allowing for the possibility that the actual amount may be very slightly higher or lower. Administrative costs are estimated at 12 percent of direct costs, based on national averages over a five year time period.

Medicaid payments are determined from the average yearly payments for adults and children and the average monthly number of adults and children receiving these payments because of their AFDC eligibility, multiplied by 53 percent. Administrative costs for Medicaid are calculated as 5 percent of the direct payments, again based on national averages over a five-year time period.

Food Stamp costs are determined from the average monthly payment (multiplied by 12) and the average monthly number of adults and children receiving Food Stamps, multiplied by 53 percent. Administrative costs for Food Stamps are estimated as 12 percent of direct costs.

For Single Birth and Single Cohort Costs, both married and unmarried teens experiencing a first birth in 1990 are included. A teen mother who is married has a higher probability of needing public assistance during the first 20 year of her child's life than does a married teen who delays childbearing until she is 20 or more years old.

CPO focuses on teens having first births because the first teen birth often triggers a sequence of events necessitating public assistance. Subsequent births are accounted for in the 53 percent calculation of welfare families begun by a teen birth and in the calculation of Single Birth and Single Cohort Costs that include costs over a 20 year period. In considering costs over the next 20 years, it should also be noted that these costs are discounted at a rate of 4 percent. This assumes that a dollar invested in 1990 will grow at an interest rate of 4 percent (after inflation) per year, compounded annually.

6. Data for 1990 Costs

Single Year Public Cost Estimates

AFDC Expenditures: $18,535,000,000 in AFDC direct cash grants, Fiscal Year (FY) 1990.[97] Administrative costs of $2,660,500,000 added for total AFDC expenditures.[98]
Food Stamp Expenditures: $59.00 average monthly Food Stamp payment per individual in FY 1990.[99] Multiplied by 11,437,042, the average monthly number of adults and children receiving AFDC in FY 1990.[100] Adjusted for 82.7 percent participation rate of AFDC households in the Food Stamp program.[101] Administrative expenses of 12 percent added.[102]
Medicaid Expenditures: 6,010,407 AFDC adults and 11,219,969 AFDC children received a total of $8,589,737,799 (to adults) plus $9,100,095,928 (to children) during FY 1990.[103] Administrative expenses of 5 percent were added.[104]

Single Birth and Single Cohort Public Costs Estimates

AFDC Cost: An average payment of $131 per recipient per month in FY 1990.[105] AFDC benefits are adjusted at a rate of 3.2 percent per year to account for inflation and discounting.[106]
Food Stamp Cost: $59.00 was the average payment per recipient per month in 1990.[107] For the years following 1990, the per recipient cost was reduced by 3 percent per year (5 percent inflation minus 2 percent increase in Food Stamp allocation). All adjusted for a 82.7 percent participation rate of AFDC households in the Food Stamp program.[108] Administrative costs of 12 percent added.[109]
Annual Medicaid Cost: On average each AFDC child cost Medicaid $811 in FY 1990, while each AFDC adult cost Medicaid $1,429.[110] These numbers remain constant for the 20 year projections because costs will keep pace with inflation.
First Births: In 1989, there were 11,006 births to girls under 15; 154,244 births to 15- to 17-year-olds, and 228,869 births to 17- to 19-year-olds. 1989 natality statistics were used to estimate 1990 births, as these are the latest available.[111]
Medicaid Costs Associated with Births: These calculations used $3,494 as the cost borne by Medicaid (including prenatal care costs) for a birth to a teenager 14 or younger; $3,224 as the cost for 15- to 17-year-olds and $2,696 as the cost for 18- to 19-year-olds. These figures are the average cost estimated by three different studies: Walentik [112], Wertheimer and Moore [113] and Burt, et al.,[114] adjusted for inflation at 4 percent per year since 1985.
Social Service Cost: Assumed to be 5 percent of AFDC cost, following Walentik's logic and example.[115]
Public Housing Cost: Assumed to be 2 percent of AFDC cost, following the examples of Walentik[116] and SRI International.[117]
AFDC, Food Stamp and Medicaid Administrative Costs: AFDC administrative costs of $2,660,500,000.[118] Food Stamp administrative costs calculated using 12 percent of direct benefits, based on historical precedent.[119] Medicaid administrative costs calculated at 5 percent of benefits, also based on historical precedent.[120]

Single Year Public Cost Estimates for the States and Cities

Florida

AFDC Expenditures: $482,233,639 in AFDC direct cash grants FY 1990. Administrative expenses of $85,832,864 added for total AFDC expenditures.[121]
Food Stamp Expenditures: $77.62 average monthly Food Stamp payment per individual in FY 1990. Multiplied by 420,167, the average monthly number of adults and children receiving AFDC in FY 1990. Adjusted for 87 percent participation rate of AFDC households in the Food Stamp program. Administrative costs of 10.2 percent were added.[122]
Medicaid Expenditures: $1,488 average adult Medicaid payment in FY 1990. Multiplied by 114,295, the average monthly number of adult Medicaid recipients who also received AFDC in FY 1990. $964, the average child Medicaid payment in FY 1990, multiplied by 379,259, the average monthly number of child Medicaid recipients who also received AFDC in FY 1990. Administrative costs of 4.2 percent were added.[125]

Kansas

AFDC Expenditures: $107,762,977 in AFDC direct cash grants in FY 1990. Administrative expenses of $12,995,488 were added for total AFDC expenditures.[124]
Food Stamp Expenditures: $55.02 average monthly Food Stamp payment per individual in FY 1990. Multiplied by 76,686, the average monthly number of adults and children receiving AFDC in FY 1990. Adjusted for 83.8 percent participation rate of AFDC households in the Food Stamp program. Administrative costs of 13.3 percent added.[125]
Medicaid Expenditures: $821.59 average Medicaid payment (adult and children combined) in FY 1990. Multiplied by 52,142, the average monthly number of adult and child Medicaid recipients who also received AFDC in FY 1990. Administrative costs of 7 percent added.[126]

New Mexico

AFDC Expenditures: $60,678,943 in AFDC direct cash grants FY 1990. Administrative costs of $9,564,832 added for total AFDC expenditures.[127]
Food Stamp Expenditures: $62.95 average monthly Food Stamp payment per individual in FY 1990.[128] Multiplied by 57,307, the average monthly number of adults and children receiving AFDC in FY 1990.[129] Adjusted for 76.2 percent participation rate of AFDC households in the Food Stamp program.[130] Administrative costs of 12 percent added.[131]
Medicaid Expenditures: $1,462 average adult Medicaid payment in FY 1990. Multiplied by 22,034, the average monthly number of adult Medicaid recipients who also received AFDC in FY 1990. $569, the average child Medicaid payment in FY 1990, multiplied by 43,909, the average monthly number of child Medicaid recipients who also received AFDC in FY 1990. Administrative costs of 3 percent were added.[132]

Ohio

AFDC Expenditures: $880,493,821 in AFDC direct cash grants FY 1990. Administrative costs of $101,334,814 added for total AFDC expenditures.[133]
Food Stamp Expenditures: $70.00 average monthly Food Stamp payment per individual in FY 1990. Multiplied by 665,128, the average monthly number of adults and children receiving AFDC in FY 1990.[134] Adjusted for 99 percent participation rate of AFDC households in the Food Stamp program.[135] Administrative costs of 12 percent added.[136]
Medicaid Expenditures: $1,214.88 average adult Medicaid payment in FY 1990. Multiplied by 218,189, the average monthly number of adult Medicaid recipients who also received AFDC in FY 1990. $799.46, the average child Medicaid payment in FY 1990, multiplied by 496,671, the average monthly number of child Medicaid recipients who also received AFDC in FY 1990.[137] Administrative costs of 5 percent were added.[138]

Oregon

AFDC Expenditures: $151,800,682 in AFDC direct cash grants FY 1990. Administrative costs of $35,400,00 added for total AFDC expenditures.[139]
Food Stamp Expenditures: $63.59 average monthly Food Stamp payment per individual in FY 1990. Multiplied by 89,021, the average monthly number of adults and children receiving AFDC in FY 1990. Adjusted for 78.8 percent participation rate of AFDC households in the Food Stamp program.[140] Administrative costs of 12 percent added.[141]
Medicaid Expenditures: $927.43 average adult Medicaid payment in FY 1990.[142] Multiplied by 27,985, the average monthly number of adult Medicaid recipients who also received AFDC in FY 1989.[143] $589.92, the average child Medicaid payment in FY 1990,[144] multiplied by 60,856, the average monthly number of child Medicaid recipients who also received AFDC in FY 1990.[145] Administrative costs of 5 percent were added.[146]

Vermont

AFDC Expenditures: $44,400,000 in AFDC direct cash grants FY 1990. Administrative costs of $5,763,441 added for total AFDC expenditures.[147]
Food Stamp Expenditures: $59.00 average monthly Food Stamp payment per individual in FY 1990.[148] Multiplied by 22,600, the average monthly number of adults and children receiving AFDC in FY 1990. Adjusted for 88 percent participation rate of AFDC households in the Food Stamp program.[149] Administrative cost of 12 percent added.[150]

Medicaid Expenditures: 5,463 AFDC adults and 7,984 AFDC children received a total of $7,671,297 (to adults) and $4,685,806 (to children) during FY 1989.[151] Administrative expenses of 5 percent were added. [152]

Wyoming

AFDC Expenditures: $19,194,605 in AFDC direct cash grants FY 1990. Administrative costs of $2,502,424 added for total AFDC expenditures.[153]

Food Stamp Expenditures: $60.85 average monthly Food Stamp payment per individual in FY 1990. Multiplied by 22,421, the average monthly number of adults and children receiving AFDC in FY 1990. Adjusted for 83 percent participation rate of AFDC households in the Food Stamp program.[154] Administrative costs of 12 percent added. [155]
Medicaid Expenditures: $1590.74 average adult Medicaid payment in FY 1990. Multiplied by 4,365, the average monthly number of adult Medicaid recipients who also received AFDC in FY 1990. $864.76, the average child Medicaid payment in FY 1990, multiplied by 7,333, the average monthly number of child Medicaid recipients who also received AFDC in FY 1990.[156] Administrative costs of 5 percent were added.[157]

Baltimore

AFDC Expenditures: $159,694,256 in AFDC direct cash grants FY 1990. Administrative costs of $16,991,867 added for total AFDC expenditures.[158]

Food Stamp Expenditures: $68.19 average monthly Food Stamp payment per individual in FY 1990. Multiplied by 102,004, the average monthly number of adults and children receiving AFDC in FY 1990. Adjusted for 72.7 percent participation rate of AFDC households in the Food Stamp program.[159] Administrative costs 12 percent added.[160]

Medicaid Expenditures: $1,362.79 average adult Medicaid payment in FY 1990. Multiplied by 33,822, the average monthly number of adult Medicaid recipients who also received AFDC in FY 1990. $735.93, the average child Medicaid payment in FY 1990, multiplied by 81,887, the average monthly number of child Medicaid recipients who also received AFDC in FY 1990.[161] Administrative costs of 5 percent were added.[162]

San Francisco

AFDC Expenditures: $87,312,182 in AFDC direct cash grants and administrative costs FY 1990.[163]

Food Stamp Expenditures: $51.73 average monthly Food Stamp payment per individual in FY 1990. Multiplied by 34,376, the average monthly number of adults and children receiving AFDC in FY 1990. Adjusted for 81.3 percent participation rate of AFDC households in the Food Stamp program.[164] Administrative costs of 12 percent added.[165]

Medicaid Expenditures: $993.34 average adult Medicaid payment in FY 1990. Multiplied by 6,136, the average monthly number of adult Medicaid recipients who also received AFDC in FY 1990. $600.45, the average child Medicaid payment in FY 1990, multiplied by 10,193, the average monthly number of child Medicaid recipients who also received AFDC in FY 1990.[166] Administrative costs of 5 percent were added.[167]

7. Endnotes

1. National Center for Health Statistics (NCHS), "Advance Report of Final Natality Statistics, 1989", *Monthly Vital Statistics Report* 40:8 (Supplement, Dec 12 1991), p. 12. In 1989, only 54% of pregnant teenagers received prenatal care in the first trimester.

2. D.M. Upchurch and J. McCarthy, 'Adolescent Childbearing and High School Completion in the 1980s: Have Things Changed?," *Family Planning Perspectives*, 21:199 (Sept/Oct 1989):199-202. In 1986, 56% of women who became mothers at age 17 or younger had completed high school.

3. F.F. Furstenberg, J. Brooks-Gunn and S.P. Morgan, "Adolescent Mothers and Their Children in Later Life," *Family Planning Perspectives*, 19:4 (Jul/Aug 1987):142-151.

4. NCHS, "Advance Report".

5. Calculations based on NCHS, Ibid.

6. Ibid.

7. E.F. Jones et. al., *Teenage Pregnancy in Industrialized Countries* (New Haven: Yale University Press, 1986). In 1981 the U.S. pregnancy rate was 96 per 1,000 girls ages 15 to 19. The comparable rates were 45 in England and Wales, 43 in France, 44 in Canada, 35 in Sweden and 14 in the Netherlands.

8. U.S. Department of Health and Human Services, Public Health Service, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (Washington, D.C.: Sept., 1990), p. 189. Family Planning Objective 5.1, would "reduce pregnancies among girls aged 17 and younger to no more than 50 per 1,000 adolescents. (Baseline: 71.1 pregnancies per 1000 girls aged 15 - 17 in 1985)." The pregnancy rate is calculated from data on births and abortions and estimates of miscarriages to teens.

9. The authorization for Title X of the Public Health Service Act, first passed in 1970, expired in 1985 but funds have continued to be appropriated by Congress. Attempts were made several times, most recently in 1991, to pass legislation reauthorizing the program, but no bill has reached the President's desk. Attacks on the program have included regulations such as the so-called "Gag Rule" that prohibits the mention of, counselling or referral for abortion with patients and the "Squeal Rule" which would have required notification of parents when minors received contraceptive drugs or devices; efforts to eliminate the program by incorporating it into block grants to the state; and the reduction of funds. The funds available for services in 1990 ($136.4 million) are $26 million less than the program high of $162 million in 1980, without adjustments for inflation. Planned Parenthood Federation of America, "Fact Sheet: 'Title X': The Nation's Family Planning Program". (Washington D.C.: Planned Parenthood Federation of America, Jan., 1991).

10. The American Teenage Study (ATS) is a 5-year longitudinal study of behaviors that contribute to the risk of adolescent pregnancy and sexually transmitted diseases. The study was approved for funding in 1989 by peer review and the National Advisory Council of the National Institute for Child Health and Human Development (NICHD). ATS would have asked sexually active teenagers explicit questions about their behavior. After federal funds had actually been committed to the research in 1991, they were withheld by the Bush Administration, a decision reinforced by votes in Congress.

11. The increase may be attributable to the recession and resulting increase in the number of Americans relying on family support programs, to the expansion of Medicaid benefits to first-time pregnant, low-income women and children under six being phased in nationwide, and to the skyrocketing costs of medical care, as well as to the increased number of teen births. By April 1990, states were required to expand Medicaid eligibility to all pregnant women and children up to age six with family incomes below 133 percent of the federal poverty level. By mid-1990, 24 states had gone beyond the requirement, and 19 extended benefits to pregnant women and infants with family incomes up to the maximum permitted of 185 percent of the federal poverty level. Federal matching funds are provided. (U.S. Congress, House Committee on Ways and Means, *Overview of Entitlement Programs: Background Materials and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, Ways and Means Committee Print 102-9, 102nd Cong, 1st sess., 1991, p.1406. All references to this work hereafter will be cited as Committee on Ways and Means, *Green Book, 1991*). This expanded coverage will provide more women with adequate prenatal and well-baby care, which can help reduce costs later.

12. Title X provided contraceptive services to 3.7 million women in FY 1990, for which the federal cost was $111.8 million. R.B. Gold and D. Daley, "Public Funding of Contraceptive, Sterilization and Abortion Services, Fiscal Year 1990", *Family Planning Perspectives*, 23:5 (Sept/Oct 1991):204-211.

13. There is a growing debate among researchers over how much of the costs associated with adolescent pregnancy might actually be saved by delaying teen births until the mother is in her twenties. The issue in part is whether young women who become mothers as teens are also more likely than the general population to require public assistance if they wait until their 20s to have their first child. Since the debate continues and an economic model would need to be developed for this study, CPO will project potential savings as it has in past years.

14. States differ significantly in their success at reducing teen births. Based on data reported by Child Trends, between 1980 and 1986, birthrates *both* for teens 15-17 *and* for teens 18-19 went down or remained relatively level in the following 41 sates: AL, AK, AR, CO, CT, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MI, MN, MS, MT, MO, NE, NV, NH, NJ,

NM, ND, OH, OK, OR, PA, SD, TN TX, UT, VT, VA, WA, WI, WV, and WY. Similarly, birthrates for both age groups increased by 2 or more per 1,000 over the same time period only in MA and RI. On the other hand, between 1986 and 1989, teen birthrates for *both* teens 15-17 *and* teens 18-19 remained relatively level or dropped in only 7 states: KS, ME, MT, NH, ND, OK, and WY. During this later period they increased 2 or more per 1,000 for both age groups in 32 states: AL, AK, AR, CA, CO, CT, DE, FL, GA, IL, IN, IA, KY, LA, MD, MA, MI, MN, MS, MO, NV, NJ, NY, NC, OH, OR, PA, RI, SC, SD, TN, and WA. States not mentioned had trends that differed depending on age group. Childtrends, "Facts at a Glance" (Washington, D.C.: Childtrends, Jan., 1992).

15. See n. 10 above.

16. F.L. Sonenstein, J.H. Pleck and L.C. Ku, "Sexual Activity, Condom Use and AIDS Awareness Among Adolescent Males," *Family Planning Perspectives* 21:152 (Jul/Aug 1989):152-158.

17. U.S. Centers for Disease Control, "Sexual Behavior Among High School Students, United States, 1990", *Morbidity and Mortality Weekly Report*, 40:51/52 (Jan. 3, 1992).

18. U.S. Centers for Disease Control, "Premarital Sexual Experience Among Adolescent Women, United States, 1970 - 1988," *Morbidity and Mortality Weekly Report* 39:51/52 (Jan. 4, 1991).

19. Ibid.

20. J.D. Forrest and S. Singh, "The Sexual and Reproductive Behavior of American Women, 1982-1988," *Family Planning Perspectives*, 22:5 (Sept/Oct 1990):206-214.

21. Calculations are based on the fact that three-fourths of all unintended teenage pregnancies occur to adolescents who do not use contraception. C.F. Westoff, "Contraceptive Paths Towards the Reduction of Unintended Pregnancy and Abortion," *Family Planning Perspectives*, 20:1 (Jan/Feb, 1988):4-13.

22. C.D. Hayes, ed., *Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing*, Vol. 1, National Academy Press; 1987, Washington, D.C..

23. In an unpublished paper, S.K. Henshaw estimates that 390,700 15- to 19- year-olds and 16,090 teens 14 and under had abortions in 1987, "U.S. Teenage Pregnancy Statistics," (New York: Alan Guttmacher Institute, Aug. 5, 1991). In 1985, there were 416,170 abortions among all teens under 20. S.K. Henshaw, et. al., *Teenage Pregnancy in the United States: The Scope of the Problem and State Responses* (New York: The Alan Guttmacher Institute, 1989). However, for valid comparisons knowledge of the abortion rate (abortions per thousand population) is necessary. The Centers for Disease Control, using less complete data, estimates that the abortion rate for teens has remained relatively unchanged. NCHS, "Advance Report".

24. The Single Cohort Cost for families begun with a teen birth due to the unavailability of abortion could be calculated by multiplying the Single Birth Costs for a given year by the number of teens having a first birth in that year who would otherwise have obtained an abortion. Thus, in 1990 for every 100,000 families begun by a teen who was forced to give birth rather than have an abortion, the costs to the taxpayer would be an additional $1,813,300,000 over the next 20 years.

25. J.D. Forrest and S. Singh, "Public-Sector Savings Resulting from Expenditures for Contraceptive Services," *Family Planning Perspectives*, 22:1 (Jan/Feb 1990):6-15.

26. Total federal spending for contraceptive services for *all* women in FY 1990, including Title X, Medicaid, Maternal and Child Health block grants, social services block grant and other sources, reached $364 million. Funding for Title X alone fell by over two-thirds. R.B. Gold and D. Daley, "Public Funding of Contraceptive, Sterilization and Abortion Services, Fiscal Year 1990."

27. Planned Parenthood Federation of America, "The Title X Family Planning Program," (Washington, D.C.: Planned Parenthood Federation of America, June 1991).

28. The Alan Guttmacher Institute, "Contraceptive Services," *Facts in Brief*, (Washington, D.C.: The Alan Guttmacher Institute, Sept 1991). While the number of teens receiving contraceptive services from federal or state programs other than Title X may have increased, these other programs -- such as Medicaid -- usually have stricter eligibility requirements, are less accessible to teens, and may be more costly to provide.

29. U.S. Centers for Disease Control, *Morbidity and Mortality Weekly Report*, Jan. 4, 1991. Very few teens are infertile, although many are at risk of infertility in later years due to high incidence of sexually transmitted disease and pelvic inflammatory disease that lead to infertility. The one million teens who are already pregnant are, of course, no longer at risk of pregnancy.

30. The National Commission to Prevent Infant Mortality, *Death Before Life: The Tragedy of Infant Mortality*, Appendix (Washington, D.C.: The National Commission to Prevent Infant Mortality, 1988).

31. Ibid.

32. Children's Defense Fund, *The Health of America's Children* (Washington, D.C.: The Children's Defense Fund, 1988).

33. Based on calculations from data in NCHS, "Advance Report".

34. U.S. Department of Health and Human Services, *Healthy People 2000*, pp. 368-370.

35. M.D. Wilson, A.K. Duggan and A. Joffe, "Rehospitalization of Infants Born to Adolescent Mothers," *Journal of Adolescent Health Care*, 11:6 (1990):510-515.

36. Children Now,"*Issue Brief: Teen Pregnancy and Parenting in California*," (Sacramento, CA: Children Now, 1992).

37. D.M. Upchurch and J. McCarthy, Adolescent Childbearing and High School Completion in the 1980s: Have Things Changed?," *Family Planning Perspectives*, 21:199 (Sept/Oct, 1989):199-202.

38. Children Now, *Teen Pregnancy and Parenting in California*.

39. Congressional Budget Office (CBO), *Sources of Support for Adolescent Mothers*, (Washington, D.C. Sept., 1990), p.13.

40. NCHS, "Advance Report."

41. CBO, *Sources of Support*, p.28

42. Calculations based on NCHS, "Advance Report".

43. CBO, *Sources of Support*, pp. 25-27.

44. Ibid., p.25.

45. J. McCarthy and J. Menken, "Marriage, Remarriage, Marital Disruption and Age at First Birth," *Family Planning Perspectives*, 11:1 (Jan/Feb, 1979):21-30.

46. S. K. Henshaw, *Teenage Pregnancy in the United States*.

47. K.A. Moore, *A State-By-State Look at Teenage Childbearing in the U.S.* (Flint, MI: Charles Stewart Mott Foundation, 1991) p. 28.

48. State of Florida Department of Health and Rehabilitative Services in cooperation with the Florida Department of Education, *Stategic Report on Teen Pregnancy* (Tallahassee, FL: January, 1991), p. i.

49. Ibid., p. iii.

50. Ibid., p. ii

51. Ibid.

52. Ibid., p. 35.

53. Ibid., p. 42.

54. Ibid., p. 43

55. Kansas Department of Health and Environment, *Kansas Annual Summary of Vital Statistics for 1990* (Topeka, KS: Division of Information Systems, Office of Research and Analysis and Office of Vital Statistics, December 1991), pp. 40, 53-54.

56. S. K. Henshaw, *Teenage Pregnancy in the U.S.*

57. Information provided by Joyce Markendorf, School and Adolescent Health Consultant, Kansas Department of Health and Environment, Bureau of Family Health, February, 1992.

58. Information provided by Johanna Bryant, Executive Director Kansas Action for Children, Topeka, KS, March, 1992.

59. S. K. Henshaw, *Teenage Pregnancy in the U.S.*

60. K.A. Moore, *A State-By-State Look*, p. 72.

61. Information from Helen Tso, Coordinator, New Mexico Office of Adolescent Pregnancy Prevention, February 10, 1992.

62. S. K. Henshaw, *Teenage Pregnancy in the U.S.*

63. K.A. Moore, *A State-By-State Look*, p. 80.

64. Ohio Governor's Task Force on Adolescent Sexuality and Pregnancy, *Teenage Pregnancy: Creating Opportunity From Crisis: Final Report* (Columbus, OH: December, 1986).

65. Information from Mary Beth Boster, Administrative Assistant, Ohio Division of Maternal and Child Health, September 16, 1991.

66. Ohio Governor's Task Force, *Final Report*.

67. Oregon Department of Human Resources, Health Division, Health Status Monitoring, Center for Health Statistics *Oregon Vital Statistics Report For Calendar Year 1989* (Portland, OR: 1990), pp. 9-1, 9-2.

68. Oregon Department of Human Resources, House Bill 3114 Committee on Adolescent Pregnancy and Parenthood, *Teen Pregnancy in Oregon: A Search for Answers, Final Report* (Salem, OR: January, 1991), p. 4.

69. Information from Anne Olson, Progam Manager, Family Planning/Adolescent Health, Health Division, Oregon Department of Human Resources, September 17, 1991.

70. K.A. Moore, *A State-By-State Look*, p. 100.

71. E. Jampol, *Report of the Governor's Task Force for Prevention of Teen Pregnancy, 1988* (Waterbury, VT: Vermont Agency of Human Services, 1989).

72. Ibid.

73. Information from Ellen Thompson, Chief of Public Health Planning and Evaluation, Vermont Department of Health, April 20, 1992.

74. Jampol, *Report of the Governor's Task Force.*

75. S. K. Henshaw, *Teenage Pregnancy in the U.S.*

76. K.A. Moore, *A State-By-State Look*, p. 110

77. Information from Nancy Neufield, Coordinator, Wyoming Governor's Teenage Pregnancy Task Force, February 5, 1992.

78. Sex Information and Education Council of the U.S. *SIECUS Report*, 20:3 (Feb/March, 1992), p. 3.

79. Nancy Neufield, February 5, 1992.

80. Baltimore City Department of Health, *Baltimore City 1990 Family Planning Initiative 21215/21217*, (Baltimore, MD: 1990), p. 1.

81. Information from Marisa Mirjafary, Research Statistician, Governor's Council on Adolescent Pregnancy, February 6, 1992.

82. K.A. Moore, *A State-By-State Look*, p. 51.

83. Baltimore City Department of Health, pp. 11-12.

84. Ibid, pp.2-4.

85. Ibid., pp. 21-22.

86. Ibid., p. 25.

87. Information from Jessica Strauss, Executive Director, Family Place, Baltimore, MD, October 21, 1991.

88. Information from Tonya Johnson, City of Baltimore Health Department, September 24, 1991.

89. Marisa Mirjafary, February 6, 1992.

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91. Information from Greg Schiller, Research Analyst II, Administrative Section, Research and Program Evaluation Unit, California Office of Family Planning, Sacramento, CA, April 21, 1992.

92. K.A. Moore, *A State-By-State Look*, p. 19.

93. Information from Bob Bailie, Project Director, University of California, San Fransisco Teen Peer Counselors Program, March 18, 1992.

94. Information from Charlene Clemens, TAPP Project Director, Family Service Agency of San Francisco, April 22, 1992.

95. CPO's Support Center for School-Based Clinics, unpublished data from "1991 survey, 1989-90 data" (Washington, D.C.: Center for Population Options, 1991).

96. D. Kirby, et.al., *An Assessment of Six School-Based Clinics: Services, impact and Potential* (Washington, D.C.: The Center for Population Options, 1989), p. 10.

97. Committee on Ways and Means, *Green Book 1991*, Section 7, Table 17, "Total, Federal and State AFDC Expenditures: Fiscal Years 1970 to 1996."

98. Ibid., Section 7, Table 19, "Average Monthly Number of AFDC Families and Recipients, Total Benefit Payments and Administrative Costs and Average Payment per Family and Person, Fiscal Year 1990 (Preliminary Data)".

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120. *U.S. Budget*, 1986.

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122. From data provided to the Southern Regional Project on Infant Mortality, Southern Governor's Association/Southern Legislative Conference, by A. Sulkes, Medicaid/Health Care Program Analyst, Florida Department of Health and Rehabilitative Services, December 6, 1991.

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124. Information from C. Rawley, Office Specialist, Management Services, Kansas Department of Social and Rehabilitation Services, February 27, 1992.

125. Ibid.

126. Ibid.

127. From data provided to D. Burke, Male Involvement Coordinator, Family Planning Program, Public Health Division, New Mexico Health and Environment Department from M. Boyd, Economist, Income Support Division, New Mexico Human Services Department, August, 1991.

128. From data provided to D. Burke (Ibid.) from E. Garcia, Income Support division, Food and Community Assistance, New Mexico Human Services Department, August, 1991.

129. Information provided to D. Burke from M. Boyd.

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131. Based on national estimate, Committee on Ways and Means, *Green Book 1985*, Appendix G, Table 1.

132. From data provided to D. Burke from B. Faurot, Medical Services Department, New Mexico Human Services Department, August, 1991.

133. Information from S. Sells, Family Support and JOBS, Ohio Department of Human Services, September, 1991.

134. Ibid.

135. Information from D. M. Schwartz, Chief, Food Stamps/TEFAP Section, Ohio Department of Human Services, September, 1991.

136. Based on national estimate, Committee on Ways and Means, *Green Book 1985*, Appendix G, Table 1.

137. Information from C. Glynn, Assistant Deputy Director for Medicaid, Ohio Department of Human Services, February, 1992.

138. Based on national estimate, *U.S. Budget*, 1986.

139. Information provided by S. Johns, Research Analyst, Budget and Research, Oregon Department of Human Resources, Adult and Family Services Division, September, 1991.

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141. Based on national estimate, Committee on Ways and Means *Green Book 1985*, Appendix G, Table 1.

142. S. Johns, September, 1991.

143. E. Armstrong and C. Waszak, *Teenage Pregnancy and Too-Early Childbearing: Public Costs, Personal Consequences*, 5th edition, (Washington, D.C.: Center for Population Options, 1990), p.41. The average monthly number of adult and child Medicaid recipients who also received AFDC in FY 1990 was unavailable, so the figures from FY 1989 were used for the calculation.

144. S. Johns, September, 1991.

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147. Information provided by S. Wallach, Vermont Department of Social Welfare, February, 19, 1992.

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153. Information from B. Masters, Deputy Director, Utilization Management, Wyoming Division of Health Care Financing, November, 1991.

154. Ibid.

155. Based on national average, Committee on Ways and Means, *Green Book 1985*, Appendix G, Table 1.

156. B. Masters, November, 1991.

157. Based on national estimate, *U.S. Budget*, 1986.

158. Information from P. Beilenson, Chief Resident, The Johns Hopkins University School of Hygiene and Public Health, Preventive Medicine Residency Program, September 24, 1991.

159. Ibid.

160. Based on national average, Committee on Ways and Means, *Green Book 1985*, Appendix G, Table 1.

161. P. Beilenson, September 24, 1991.

162. Based on national average, *U.S. Budget*, 1986.

163. Information from M. Porter, Statistical Services Bureau, California Department of Social Services, Sacramento, CA, February 24, 1992.

164. Information from B. Maxfield, Department of Health Services, Medical Care Statistics Section, California Department of Social Services, Sacramento, CA, March 3, 1992.

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166. B. Maxfield, March 3, 1992.

167. Based on national average, *U.S. Budget*, 1986.

Notes

HEALTHY PEOPLE 2000: NATIONAL HEALTH OBJECTIVES FOR FAMILY PLANNING

1) Reduce pregnancies among girls aged 17 and younger to no more than 50 per 1,000 adolescents. (Baseline: 71.1 pregnancies per 1,000 girls aged 15 through 17 in 1985.)

2) Reduce to no more than 30 percent the proportion of all pregnancies that are unintended. (Baseline: 56 percent of pregnancies in the previous 5 years were unintended, either unwanted or earlier than desired, in 1988.)

3) Reduce the prevalence of infertility to no more than 6.5 percent. (Baseline: 7.9 percent of married couples with wives aged 15 through 44 in 1988.)

4) Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17. (Baseline: 27 percent of girls and 33 percent of boys by age 15; 50 percent of girls and 66 percent of boys by age 17; reported in 1988.)

5) Increase to at least 40 percent the proportion of ever sexually active adolescents aged 17 and younger who have abstained from sexual activity for the previous 3 months. (Baseline: 26 percent of sexually active girls through 17 in 1988.)

6) Increase to at least 90 percent the proportion of sexually active, unmarried people aged 19 and younger who use contraception, especially combined method contraception that both effectively prevents pregnancy and provides barrier protection against disease. (Baseline: 78 percent at most recent intercourse and 63 percent at first intercourse; 2 percent used oral contraceptives and the condom at most recent intercourse; among young women aged 15 - 19 reporting in 1988.)

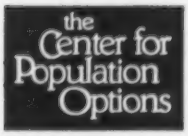
7) Increase the effectiveness with which family planning methods are used, as measured by a decrease to no more than 5 percent in the proportion of couples experiencing pregnancy despite use of a contraceptive method. (Baseline: Approximately 10 percent of women using reversible contraceptive methods experienced an unintended pregnancy in 1982.)

8) Increase to at least 85 percent the proportion of people aged 10 through 18 who have discussed human sexuality, including values surrounding sexuality, with their parents and/or have received information through another parentally endorsed source, such as youth, school, or religious programs. (Baseline: 66 percent of people aged 13 through 18 have discussed sexuality with their parents; reported in 1986.)

9) Increase to at least 90 percent the proportion of pregnancy counselors who offer positive, accurate information about adoption to their unmarried patients with unintended pregnancies. (Baseline: 60 percent of pregnancy counselors in 1984.)

10) Increase to at least 60 percent the proportion of primary care providers who provide age-appropriate preconception care and counseling. (Baseline data available in 1992.)

11) Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment clinics, drug treatment centers, and primary care clinics that screen, diagnose, treat, counsel, and provide or refer for partner notification services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, chlamydia). (Baseline: 40 percent of family planing clinics for bacterial sexually transmitted diseases in 1989.)



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